Total Health Link | PROGRESSIVE SPORTS MEDICINE.CA | ELITE PERFORMANCE CENTER epc

MEDICAL INFORMATION

Patient Name:	Date Of Birth: YYYY/MM/DD	Occupation:

Address: Street | Unit # | City | Postal Code

Home Phone Number:	Cell Phone Number:	E-Mail Address:
( )	( )	

Emergency Contact:	Relationship:	Phone Number:
		( )

How did you hear about us?

- ❑ Doctor Referral_____________
- ❑ Patient Referral _____________
- ❑ Yellow Pages
- ❑ Website
- ❑ Other ___________________

Family Doctor:	Phone Number:	Practice Location:
	( )	

Current Medications:

Please list and date any Surgeries:

Please list the presence of any internal pins, wires and artificial joints:

Is this condition:	❑ Motor Vehicle Accident	❑ WSIB	❑ Sports Injury	❑ Other:

What is your chief complaint:

Any other areas of concern:

How long have you had your present pain?

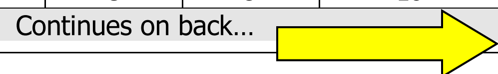
Did your present pain begin with a specific incident?

- ❑ No
- ❑ Yes (if yes please explain)

Please rate your pain level on the chart below:

No Pain								Very Painful	
1	2	3	4	5	6	7	8	9	10

Continues on back...



Have you had this problem before?
- ❑ No
- ❑ Yes (if yes, how often and how long does the pain last?)

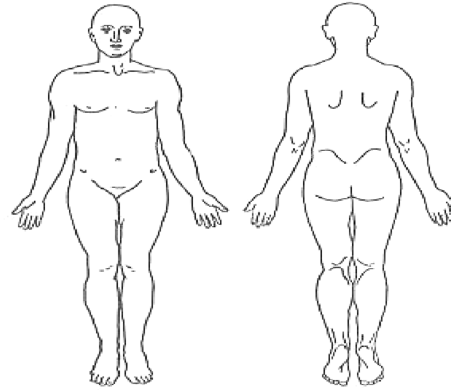
Date of Health History
1.___________________
2.___________________
3.___________________

INDICATE AREAS OF PAIN OR DISCOMFORT

Mark the areas on the bodies where you feel the described sensations.

Indicate areas of:

Numbness **))))**
Pins & Needles **OOOO**
Burning **XXXX**
Aching ********
Stabbing **////**



MEDICAL HISTORY

Cardiovascular
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Heart Failure
- ❑ Heart Disease
- ❑ Myocardial Infarction
- ❑ Phlebitis
- ❑ Cardio-Vascular Accident
- ❑ Stroke
- ❑ Pacemaker
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Osteoarthritis
- ❑ Lymphedema
- ❑ Other: ____________________

Respiratory
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking
- ❑ Other: ____________________

Infectious Diseases
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV
- Other:_____________________

Digestive
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Nausea/Vomiting
- ❑ Irritable Bowel Syndrome
- ❑ Liver/Gall Bladder
- ❑ Kidney/Bladder

Nervous System
- ❑ Herpes/Shingles
- ❑ Numbness/Tingling
- ❑ Chronic Pain
- ❑ Fatigue
- ❑ Sleep Disorder
- ❑ Loss of Sensation
- ❑ Other: ____________________

Skin
- ❑ Allergies (anaphylactic)
- ❑ Rashes
- ❑ Athletes Foot
- ❑ Warts
- ❑ Cold Sores
- ❑ Eczema/Psoriasis
- ❑ Other: (contagious) _________________

Reproductive
- ❑ Pregnancy (trimester___)
- ❑ PMS
- ❑ Other: ____________________

Musculo-Skeletal
- ❑ Bone or Joint Disease
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Fractures
- ❑ Osteoporosis
- ❑ Osteoarthritis
- ❑ Arthritis
- ❑ Sprains/Strains
- ❑ Swelling
- ❑ Stiffness
- ❑ Headaches
- ❑ Migraines
- ❑ Spasms/Cramps
- ❑ Pain (check area): _Jaw _Neck _Shoulder _Elbow _Wrist _ Hip _Knee _Ankle _Back _Foot _Toes

Other
- ❑ Drug/Alcohol addiction
- ❑ Nicotine/Caffeine addiction
- ❑ Diabetes
- ❑ Vision/Hearing Loss
- ❑ Cancer
- ❑ Epilepsy
- ❑ Allergies (please list)
- ❑ Other: ____________________